		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022889

Facility Name: FRANKFORT TERRACE

Address: 40 N. SMITH ST. (Number) FRANKFORT (City) 60423 (Zip Code)

County: WILL

Telephone Number: (847) 674 - 5795 **Fax #** (847) 674 - 5794

IDPA ID Number: 36-2883294

Date of Initial License for Current Owners: 10/01/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	120	Intermediate (ICF)	120	43,800	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	36,756	4,038	838	41,632	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,756	4,038	838	41,632	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.05%

D. How many bed-hold days during this year were paid by Public Aid?
1,683 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	139,655	12,882	5,940	158,477		158,477	0	158,477			1
2	Food Purchase		162,856		162,856		162,856	(665)	162,191			2
3	Housekeeping	144,688	14,418	0	159,106		159,106	0	159,106			3
4	Laundry	62,866	12,458	6,307	81,631		81,631	0	81,631			4
5	Heat and Other Utilities			121,588	121,588		121,588	310	121,898			5
6	Maintenance	64,718	11,558	17,601	93,877		93,877	935	94,812			6
7	Other (specify):*			8,181	8,181		8,181	88	8,269			7
8	**TOTAL General Services**	411,927	214,172	159,617	785,716	0	785,716	668	786,384			8
	B. Health Care and Programs											
9	Medical Director	0		2,500	2,500		2,500	0	2,500			9
10	Nursing and Medical Records	1,093,041	44,355	10,795	1,148,191		1,148,191	0	1,148,191			10
10a	Therapy	110,902		5,592	116,494		116,494	0	116,494			10a
11	Activities	80,039	2,116	2,416	84,571		84,571	0	84,571			11
12	Social Services	0		999	999		999	0	999			12
13	Nurse Aide Training			876	876		876	0	876			13
14	Program Transportation			0	0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	1,283,982	46,471	23,178	1,353,631	0	1,353,631	0	1,353,631			16
	C. General Administration											
17	Administrative	93,191		361,250	454,441		454,441	(327,507)	126,934			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			51,936	51,936		51,936	(295)	51,641			19
20	Dues, Fees, Subscriptions & Promotions			20,670	20,670		20,670	(11,260)	9,410			20
21	Clerical & General Office Expenses	44,982	7,835	99,046	151,863		151,863	(51,077)	100,786			21
22	Employee Benefits & Payroll Taxes			294,189	294,189		294,189	(1,095)	293,094			22
23	Inservice Training & Education			1,060	1,060		1,060	74	1,134			23
24	Travel and Seminar			0	0		0	0	0			24
25	Other Admin. Staff Transportation			18,149	18,149		18,149	518	18,667			25
26	Insurance-Prop.Liab.Malpractice			69,755	69,755		69,755	2,676	72,431			26
27	Other (specify):*			3,387	3,387		3,387	3,774	7,161			27
28	**TOTAL General Administration**	138,173	7,835	919,442	1,065,450	0	1,065,450	(384,192)	681,258			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,834,082	268,478	1,102,237	3,204,797	0	3,204,797	(383,524)	2,821,273			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FRANKFORT TERRACE #0022889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			43,392	43,392		43,392	(2,403)	40,989			30
31	Amortization of Pre-Op. & Org.			31,815	31,815		31,815	0	31,815			31
32	Interest			146,862	146,862		146,862	1,467	148,329			32
33	Real Estate Taxes			49,116	49,116		49,116	700	49,816			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles			31,087	31,087		31,087	3,311	34,398			35
36	Other (specify):* OFFICE RENT			9,000	9,000		9,000	(9,000)	0			36
37	**TOTAL Ownership**			311,272	311,272	0	311,272	(5,925)	305,347			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0		0	0	0			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			65,700	65,700		65,700	0	65,700			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	0	65,700	65,700	0	65,700	0	65,700			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,834,082	268,478	1,479,209	3,581,769	0	3,581,769	(389,449)	3,192,320			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,721)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(665)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	0	21		18
19	Entertainment	0	20		19
20	Contributions	(10,792)	20		20
21	Owner or Key-Man Insurance	(1,095)	22		21
22	Special Legal Fees & Legal Retainers	(8,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,387)	27		24
25	Fund Raising, Advertising and Promotional	0	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,053)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(5,028)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (33,741)		$ 0	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(355,708)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (355,708)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (389,449)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

FRANKFORT TERRACE

ID# 0022889

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ -1628	6	1
2	STAFF DEVELOPMENT	(3,400)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(5,028)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(665)	0	0	0	0	0	0	0	0	0	0	(665)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	310	0	0	0	0	0	0	0	310	5
6	Maintenance	(1,628)	0	1,698	865	0	0	0	0	0	0	0	935	6
7	Other (specify):*	0	0	88	0	0	0	0	0	0	0	0	88	7
8	**TOTAL General Services**	(2,293)	0	1,786	1,175	0	0	0	0	0	0	0	668	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(327,507)	0	0	0	0	0	0	0	0	0	(327,507)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,000)	368	7,264	73	0	0	0	0	0	0	0	(295)	19
20	Fees, Subscriptions & Promotions	(11,845)	0	585	0	0	0	0	0	0	0	0	(11,260)	20
21	Clerical & General Office Expenses	(3,400)	5,699	(53,684)	308	0	0	0	0	0	0	0	(51,077)	21
22	Employee Benefits & Payroll Taxes	(1,095)	0	0	0	0	0	0	0	0	0	0	(1,095)	22
23	Inservice Training & Education	0	0	74	0	0	0	0	0	0	0	0	74	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	389	129	0	0	0	0	0	0	0	0	518	25
26	Insurance-Prop.Liab.Malpractice	0	666	1,930	80	0	0	0	0	0	0	0	2,676	26
27	Other (specify):*	(3,387)	2,390	4,771	0	0	0	0	0	0	0	0	3,774	27
28	**TOTAL General Administration**	(27,727)	(317,995)	(38,931)	461	0	0	0	0	0	0	0	(384,192)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(30,020)	(317,995)	(37,145)	1,636	0	0	0	0	0	0	0	(383,524)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FRANKFORT TERRACE # 0022889 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(3,721)	255	326	737	0	0	0	0	0	0	0	(2,403)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	357	1,110	0	0	0	0	0	0	0	1,467	32
33	Real Estate Taxes	0	0	0	700	0	0	0	0	0	0	0	700	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	1,119	2,192	0	0	0	0	0	0	0	0	3,311	35
36	Other (specify):*	0	0	0	(9,000)	0	0	0	0	0	0	0	(9,000)	36
37	**TOTAL Ownership**	(3,721)	1,374	2,875	(6,453)	0	0	0	0	0	0	0	(5,925)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(33,741)	(316,621)	(34,270)	(4,817)	0	0	0	0	0	0	0	(389,449)	45

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSLT
				IME REALTY	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 340,000	EMI ENTERPRISES		$	$ (340,000)	1
2	V								2
3	V								3
4	V	17	OFFICERS SALARY				12,493	12,493	4
5	V	19	ACCOUNTING FEES				368	368	5
6	V	21	OFFICE EXPENSE				5,699	5,699	6
7	V	25	TRANSPORTATION				389	389	7
8	V	26	INSURANCE				666	666	8
9	V	27	EMPLOYEE BENEFITS				2,390	2,390	9
10	V	30	DEPRECIATION				255	255	10
11	V	35	AUTO LEASE				1,119	1,119	11
12	V								12
13	V								13
14	Total			$ 340,000			$ 23,379	$ * (316,621)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		21	BOOKKEEPING FEES	$ 82,080	EKS MANAGEMENT, INC.		$	$ (82,080)	15
16	V									16
17	V									17
18	V		6	PAINTING / DECORATING				1,698	1,698	18
19	V		7	SCAVENGER				88	88	19
20	V		19	PROFESSIONAL FEES				7,264	7,264	20
21	V		20	WANT ADS/BACKGR CKS				585	585	21
22	V		21	OFFICE EXPENSE				28,396	28,396	22
23	V		23	SEMINARS				74	74	23
24	V		25	TRANSPORTATION				129	129	24
25	V		26	INSURANCE				1,930	1,930	25
26	V		27	EMPLOYEE BENEFITS				4,771	4,771	26
27	V		30	DEPRECIATION				326	326	27
28	V		32	INTEREST-INSURANCE FIN.				357	357	28
29	V		35	EQUIPMENT RENT				2,192	2,192	29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 82,080			$ 47,810	$ * (34,270)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 9,000	IME REALTY CORP		$	$ (9,000)	15
16	V								16
17	V								17
18	V	5	UTILITIES				310	310	18
19	V	6	REPAIRS & MAINTENANCE				865	865	19
20	V	19	PROFESSIONAL FEES				73	73	20
21	V	21	OFFICE EXPENSE				308	308	21
22	V	26	INSURANCE				80	80	22
23	V	30	DEPRECIATION				737	737	23
24	V	32	INTEREST				1,110	1,110	24
25	V	33	RE TAX				700	700	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,000			$ 4,183	$ * (4,817)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	BERNARD COHEN	GENERAL PARTNE	ADMINISTRATION		SCHEDULE ATTACHED			MGMT FEES	$ 21,250	17-3	1
2	MORRIS ESFORMES	GENERAL PARTNE	ADMINISTRATION					SALARY	12,493	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 33,743		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES, INC.
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	616,513	11	$ 185,000	$ 185,000	41,632	$ 12,493	1
2	19	ACCOUNTING FEES	PATIENT DAYS	616,513	11	5,451		41,632	368	2
3	21	OFFICE EXPENSE	PATIENT DAYS	616,513	11	84,399	60,672	41,632	5,699	3
4	25	TRANSPORTATION	PATIENT DAYS	616,513	11	5,763		41,632	389	4
5	26	INSURANCE	PATIENT DAYS	616,513	11	9,863		41,632	666	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	616,513	11	35,399		41,632	2,390	6
7	30	DEPRECIATION	PATIENT DAYS	616,513	11	3,788		41,632	255	7
8	35	AUTO LEASE	PATIENT DAYS	616,513	11	16,569		41,632	1,119	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 346,232	$ 245,672		$ 23,379	25

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MGMT,
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTING / DECORATING	PATIENT DAYS	616,513	11	$ 25,141	$	41,632	$ 1,698	1
2	7	SCAVENGER	PATIENT DAYS	616,513	11	1,310		41,632	88	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	616,513	11	107,563	91,129	41,632	7,264	3
4	20	WANT ADS	PATIENT DAYS	616,513	11	8,660		41,632	585	4
5	21	OFFICE EXPENSE	PATIENT DAYS	616,513	11	420,511	316,407	41,632	28,396	5
6	23	SEMINARS	PATIENT DAYS	616,513	11	1,100		41,632	74	6
7	25	TRANSPORTATION	PATIENT DAYS	616,513	11	1,912		41,632	129	7
8	26	INSURANCE	PATIENT DAYS	616,513	11	28,579		41,632	1,930	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	616,513	11	70,657		41,632	4,771	9
10	30	DEPRECIATION	PATIENT DAYS	616,513	11	4,837		41,632	326	10
11	32	INTEREST-INSURANCE FIN.	PATIENT DAYS	616,513	11	5,286		41,632	357	11
12	35	EQUIPMENT RENT	PATIENT DAYS	616,513	11	32,463		41,632	2,192	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 708,019	$ 407,536		$ 47,810	25

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP.
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	203,249	11	$ 6,990	$	9,000	$ 310	1
2	6	REPAIRS & MAINTENANCE	PATIENT DAYS	203,249	11	19,525		9,000	865	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	203,249	11	1,650		9,000	73	3
4	21	OFFICE EXPENSE	PATIENT DAYS	203,249	11	6,958		9,000	308	4
5	26	INSURANCE	PATIENT DAYS	203,249	11	1,798		9,000	80	5
6	30	DEPRECIATION	PATIENT DAYS	203,249	11	16,647		9,000	737	6
7	32	INTEREST	PATIENT DAYS	203,249	11	25,074		9,000	1,110	7
8	33	RE TAX	PATIENT DAYS	203,249	11	15,815		9,000	700	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 94,457	$		$ 4,183	25

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LASALLE BANK		X	MORTGAGE		08/01/96	$ 2,720,000	$ 0			$ 124,297	1
2	LASALLE BANK		X	MORTGAGE		11/01/01	2,218,297	2,209,861			21,769	2
3	LASALLE BANK		X	LETTER OF CREDIT							796	3
4												4
5												5
	Working Capital											
6												6
7	RELATED PARTY										1,467	7
8												8
9	TOTAL Facility Related						$ 4,938,297	$ 2,209,861			$ 148,329	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 4,938,297	$ 2,209,861			$ 148,329	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	50,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	49,316	2
3. Under or (over) accrual (line 2 minus line 1).	$	(684)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	49,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	49,116	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	45,001	8
	1997	45,902	9
	1998	47,210	10
	1999	49,531	11
	2000	49,316	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FRANKFORT TERRACE COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0022889

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-09-21-410-021-0000	NURSING HOME	$ 45,919.00	$ 45,919.00
2.	19-09-21-410-007-0000	NURSING HOME	$ 3,397.00	$ 3,397.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 49,316.00	$ 49,316.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,373 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1976	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1976	1972	$ 1,233,000	$ 12,330	25	$ 12,330	$	$ 1,233,000	4
5											5
6											6
7											7
8	REL PARTY					604		604			8
	Improvement Type**										
9	BUILDING IMPROVEMENTS			1980	7,438	0	5			7,438	9
10	BUILDING IMPROVEMENTS			1981	3,000	0	15			3,000	10
11	BUILDING IMPROVEMENTS			1983	3,138	0	5			3,138	11
12	BUILDING IMPROVEMENTS			1987	8,474	269	31.5	269		3,889	12
13	BUILDING IMPROVEMENTS			1988	51,503	1,635	31.5	1,635		22,822	13
14	BUILDING IMPROVEMENTS			1988	13,056	415	31.5	415		5,559	14
15	BUILDING IMPROVEMENTS			1990	6,944	220	31.5	220		2,546	15
16	BUILDING IMPROVEMENTS			1992	21,890	695	31.5	695		6,559	16
17	BUILDING IMPROVEMENTS			1993	4,065	129	31.5	129		1,123	17
18	BUILDING IMPROVEMENTS			1993	24,826	636	39	636		5,240	18
19	BUILDING IMPROVEMENTS			1994	7,630	196	39	196		1,447	19
20	FLOORING			1995	4,350	112	39	112		751	20
21	ROOFING			1995	10,000	256	39	256		1,675	21
22	FLOORING			1995	1,712	44	39	44		280	22
23	ROOFING			1995	5,200	133	39	133		837	23
24	FLOORING			1995	14,193	364	39	364		2,199	24
25	PARKING LOT LIGHT			1996	5,700	380	15	380		2,090	25
26	ROOFING			1996	10,330	265	39	265		1,469	26
27	LANDSCAPE			1997	6,700	447	15	447		2,011	27
28	DOOR ALARM			1997	1,980	51	39	51		219	28
29	SHOWER			1997	1,660	43	39	43		177	29
30	TILE			1998	6,250	160	39	160		634	30
31	FLOORING			1998	2,650	68	39	68		264	31
32	AWNING			1999	3,530	235	15	235		588	32
33	FLOORING			1999	4,700	121	39	121		338	33
34	CARPET/COVE BASE			2000	11,042	2,704	20	552	(2,152)	591	34
35	ROOFTOP AC			2000	2,490	91	27.5	91		95	35
36	VERTICAL BLINDS			2001	974	174	20	49		49	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CUBICLE CURTAINS	2001	$ 19,810	$ 707	20	$ 991	$ 284	$ 991	37
38	ROOF REPAIR	2001	4,450	155	27.5	155		155	38
39	FLOOR TILE	2001	18,654	289	27.5	289		289	39
40	ROOFTOP HEAT COOL	2001	1,734	29	27.5	29		29	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,523,073	$ 23,957		$ 21,964	$ (1,868)	$ 1,311,492	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 172,194	$ 17,372	$ 17,128	$ (244)	5-10 YRS	$ 84,037	71
72	Current Year Purchases	23,655	2,667	1,183	(1,484)	10 YRS	1,183	72
73	Fully Depreciated Assets	334,389			0		334,389	73
74	RELATED PARTY		714	714	0			74
75	TOTALS	$ 530,238	$ 20,753	$ 19,025	$ (1,728)		$ 419,609	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,153,311	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 44,710	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 40,989	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,721)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,731,101	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 19,948 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	MAINT, ACTIVITY	01 CHEVY EXP VAN	$ 700.00	$ 11,139	17
18					18
19					19
20					20
21	TOTAL		$ 700.00	$ 11,139	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$ 660	$	$ 660
2	Books and Supplies			216		216
3	Classroom Wages	(a)				0
4	Clinical Wages	(b)				0
5	In-House Trainer Wages	(c)				0
6	Transportation					0
7	Contractual Payments					0
8	Nurse Aide Competency Tests					0
9	TOTALS		$ 0	$ 876	$ 0	$ 876
10	SUM OF line 9, col. 1 and 2	(e)	$ 876			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 0

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	0
DROP-OUTS	
1. From this facility	0
2. From other facilities (f)	0
TOTAL TRAINED	2

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$ 0	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 90,131	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	842,175		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	101,439		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	307,274		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,341,019	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	1,095,070		11
12	Long-Term Investments			12
13	Land	100,000		13
14	Buildings, at Historical Cost	1,233,000		14
15	Leasehold Improvements, at Historical Cost	290,073		15
16	Equipment, at Historical Cost	530,238		16
17	Accumulated Depreciation (book methods)	(1,788,148)		17
18	Deferred Charges	17,075		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,477,308	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,818,327	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 136,276	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25		28
29	Short-Term Notes Payable	211,000		29
30	Accrued Salaries Payable	57,538		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,645		31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,800		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 479,284	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,209,861		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,209,861	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,689,145	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 129,182	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,818,327	$ 0	48

***(See instructions.)**

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 81,331	1
2	Restatements (describe):		2
3	IL REPLACEMENT TAX	5,447	3
4	POST CLOSING ENTRIES	(70,822)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 15,956	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	320,219	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(206,993)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 113,226	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 129,182	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,822,625	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,822,625	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	79,363	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 79,363	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,901,988	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	785,716	31
32	Health Care	1,353,631	32
33	General Administration	1,065,450	33
	B. Capital Expense		
34	Ownership	311,272	34
	C. Ancillary Expense		
35	Special Cost Centers	0	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,581,769	40
41	**Income before Income Taxes (line 30 minus line 40)****	320,219	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 320,219	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,269	2,476	$ 56,669	$ 22.89	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,152	12,452	263,264	21.14	3
4	Licensed Practical Nurses	5,683	6,287	107,640	17.12	4
5	Nurse Aides & Orderlies	60,559	65,661	605,294	9.22	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,525	12,670	110,902	8.75	8
9	Activity Director					9
10	Activity Assistants	7,533	8,466	80,039	9.45	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,929	18,430	139,655	7.58	15
16	Dishwashers					16
17	Maintenance Workers	5,615	5,655	64,718	11.44	17
18	Housekeepers	18,440	19,908	144,688	7.27	18
19	Laundry	7,062	7,914	62,866	7.94	19
20	Administrator	2,092	2,253	93,191	41.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,838	4,976	44,982	9.04	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,778	2,051	19,145	9.33	31
32	Other Health C: MDS COORDIN.	2,080	2,274	41,029	18.04	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,555	171,473	$ 1,834,082 *	$ 10.70	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 5,940	1-3	35
36	Medical Director	O	2,500	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	1,200	10-3	38
39	Pharmacist Consultant	H	2,640	10-3	39
40	Physical Therapy Consultant	L	4,093	10a-3	40
41	Occupational Therapy Consultant	Y	1,499	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,416	11-3	44
45	Social Service Consultant	E	999	12-3	45
46	Other(specify) DENTAL	S	3,300	10-3	46
47	PSYCHO-SOCIAL		2,012	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 26,599		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 962		50
51	Licensed Practical Nurses				51
52	Nurse Aides		181		52
53	TOTAL (lines 50 - 52)		$ 1,143		53

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RANDY LEBEAU	ADMIN	0	$ 93,191
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 93,191

B. Administrative - Other

Description	Amount
EMI ENTERPRISES	$ 340,000
BERNARD COHEN	21,250
TOTAL (agree to Schedule V, line 17, col. 3)	$ 361,250
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 3,473
ALPHA CPX	DATA PROCESSING	22
MAXX SOURCE	DATA PROCESSING	1,500
NURSING CARE SYSTEM	DATA PROCESSING	5,458
MID AMERICA	DATA PROCESSING	1,320
KRUPNICK,BOKOR,KAGDA	ACCOUNTING	11,100
LAWRENCE SCHWARTZ	LEGAL	26,000
PERSONNEL PLANNERS	UC CONSULTANT	609
LINCOLNWOOD FUNDING	REMARKETING	2,454
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 51,936

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 56,002
Unemployment Compensation Insurance		11,099
FICA Taxes		139,527
Employee Health Insurance		76,108
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		3,094
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		7,264
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		1,095
INSURANCE - EXECUTIVE LIFE	VI 21	(1,095)
TOTAL (agree to Schedule V, line 22, col.8)		$ 293,094

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	5,581
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	1,053
TRUST FEES/CONTRIBUTIONS	10,792
RELATED PARTY	585
DUES & SUBSCRIPTIONS	2,614
LICENSES & PERMITS	430
TRUST FEES/CONTRIBUTIONS	(10,792)
Less: Public Relations Expense	(0)
Non-allowable advertising	(0)
Yellow page advertising	(1,053)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,410

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
(agree to Sch. V,	
TOTAL line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	1998	$ 3,250	3 YRS	$ 542	$ 1,083	$ 1,083	$ 542	$	$	$	$	$
2	PAINT/DECORATING	1999	2,488	3 YRS		415	829	829	415				
3	PAINT/DECORATING	2000	2,634	3 YRS			439	878	878	439			
4	PAINT/DECORATING	2001	4,652	3 YRS				775	1,551	1,551	775		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 13,024		$ 542	$ 1,498	$ 2,351	$ 3,024	$ 2,844	$ 1,990	$ 775	$	$

Facility Name & ID Number FRANKFORT TERRACE # 0022889 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? YES

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE $2,394

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 4,293 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 65,700
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: FRANKFORT TERRACE **#0022889** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,940	
	REPAIRS & MAINTENANCE		0	
			0	5,940
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		6,307	
			0	6,307
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		33,994	
	ELECTRICITY		31,067	
	WATER		56,527	
	CABLE TV - LOBBY		0	
			0	121,588
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,950	
	PAINTING & DECORATING		4,652	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		3,559	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		264	
	EXTERMINATING SERVICE		1,935	
	FIRE SERVICE		2,241	
			0	
			0	
			0	17,601
7	**OTHER**			
	SCAVENGER		5,707	
	SECURITY SERVICE		2,474	8,181
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	2,500	2,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	1,143	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	2,012	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	2,640	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	1,200	
	DENTAL		3,300	
	PSYCHOLOGICAL SERVICES		500	10,795
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	4,093	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	1,499	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	5,592
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,416	
			0	2,416
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	999	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	999
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	876	876

Facility Name & ID Number FRANKFORT TERRACE **#0022889** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	361,250	361,250
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	11,773	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	40,163	
			0	51,936
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	0	
	EMPLOYEE WANT ADS	XIX F	5,581	
	CONTRIBUTIONS	VI 20 XIX F	300	
	DUES & SUBSCRIPTIONS	XIX F	2,614	
	LICENSES & PERMITS	XIX F	630	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,053	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	10,492	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	20,670
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		725	
	EQUIPMENT REPAIR & MAINTENANCE		1,020	
	OUTSIDE CLERICAL SERVICES		82,080	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		11,821	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		3,400	99,046

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	139,527	
	UNEMPLOYMENT COMPENSATION	XIX D	11,099	
	WORKERS COMPENSATION INSURANC	XIX D	56,002	
	HOSPITALIZATION INSURANCE	XIX D	76,108	
	EMPLOYEE BENEFITS - OTHER	XIX D	3,094	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	1,095	
	PENSION/PROFIT SHARING PLANS	XIX D	7,264	
	CHICAGO HEAD TAX	XIX D	0	294,189
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,060	1,060
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		18,149	18,149
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		69,755	69,755
27	**OTHER**			
	BAD DEBTS	VI 24	3,387	
			0	3,387

GRAND TOTAL COLUMN 3 OTHER 1,102,237

FRANKFORT TERRACE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	162,856	PATIENT MEALS	124896
LESS SALES TAX	(665)	ADD EMPLOYEE MEALS	0
NET FOOD	163521	TOTAL MEALS/YEAR	124896
TOTAL PATIENT CENSUS	41,632	NET FOOD	163521
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	124896
TOTAL PATIENT MEALS	124896	COST PER MEAL	1.31
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		